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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	002392	A. BUILDING _____ B. WING _____	01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT TOWNE CENTRE, THE	7252 ARTHUR BOULEVARD MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure survey. Survey dates: January 18 and 19, 2011 Facility Number: 002392 Provider Number: 002392 Aim Number: N/A Survey Team: Regina Sanders, RN. TC Kelly Sizemore, RN Census Bed Type: Residential: 47 Total: 47 Census Payor Type: Other: 47 Total: 47 Sample: 07 Supplemental sample: 07 These State Residential findings are in accordance with 410 IAC 16.2-5. Quality review completed 1-21-11 Cathy Emswiller RN	R 000	***DISCLAIMER:*** ***Preparation and implementation of this plan of correction does not constitute admission or agreement by The Terrace at Towne Centre of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated 01/19/2011. The Terrace at Towne Centre specifically reserves the right to move to strike or exclude this document as evidence in any civil action not related directly to the licensing and/or certification of this facility or provider.***	
R 036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights-Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is,	R 036		

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R 036	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to notify a resident's physician related to high blood sugars for 1 of 7 residents reviewed for physician notification in a sample of 7. (resident #23) Findings include: Resident #23's record was reviewed on 01/19/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitis, end stage renal disease, and severe peripheral vascular disease. The signed physician's recapitulation orders, dated 12/10, indicated an order for glucometer checks (blood sugar monitoring) twice a day at 6 a.m. and 4 p.m. and to notify the physician if the blood sugar was over 200 or less than 70. The physician's order indicated the resident was on a sliding scale (insulin given per blood sugar result) for insulin. The coverage for the insulin indicated to give eight units of Novolin N (insulin) for a blood sugar between 301-350 and if the blood sugar was greater than 350, the facility was to notify the physician. The Medication Administration Record (MAR), dated 12/10, indicated to notify the physician if the blood sugar was above 200 or less than 70. The MAR, dated 12/10, indicated the following 4 p.m. blood sugar results: 12/19/10-229 12/21/10-233	R 036	R 036 1. Resident #23 had two different blood sugar monitoring orders. The order to notify the physician if the blood sugar was above 200 or less than 70 was in error. The two different orders were missed in the recap review. The nurse doing the review concentrated mainly on the medications and did not pick up the two different orders. The attending physician was contacted and the error blood sugar monitoring order was discontinued. 2. All insulin dependent residents were checked for duplicate blood sugar monitoring orders. None were found and no other residents were affected. 3. The review of physician recaps will now include the order as well as medications. The nurse doing the recaps has been inserviced 2-1-11 regarding the scope of the recaps reviews. Insulin orders will be changed to the medication side of the MARs starting in March. This will provide addition pharmacy review to recheck the insulin orders. Licensed staff will be inserviced on the change with the MARs 2-25-11. 4. The Resident Care Coordinator will review monthly the insulin dependent residents' physician recap orders. This monthly review of insulin dependent resident recaps will be ongoing. Results	

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R 036	Continued From page 2 12/24/10-345 12/28/10-301 12/30/10-265 12/31/10-338 There was a lack of documentation on the MAR, dated 12/10 and in the resident's nurses' notes, dated 12/01/10 through 01/01/11, to indicate the physician had been notified of the blood sugars above 200. The signed physician's recapitulation orders, dated 01/11, indicated an order for glucometer checks twice a day at 6 a.m. and 4 p.m. and to notify the physician if the blood sugar was over 200 or less than 70. The physician's order indicated the resident was on a sliding scale for insulin. The coverage for the insulin indicated to give eight units of Novolin N (insulin) for a blood sugar between 301-350 and if the blood sugar was greater than 350, the facility was to notify the physician. The MAR, dated 01/11, indicated to notify the physician if the blood sugar was above 200 or less than 70. The MAR, dated 01/11, indicated the resident's blood sugar at 6 a.m. on 01/02/11 was 313. The MAR, dated 01/11, indicated the following 4 p.m. blood sugar results: 01/07/11-268 01/11/11-301 01/13/11-228 01/14/11-350 01/15/11-312 01/16/11-286 01/17/11-226 01/18/11-241	R 036	of the review will be shared with the Quality Assurance Committee. 5. Completion date – February 4, 2011.	

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R 036	Continued From page 3 There was a lack of documentation on the MAR, dated 01/11 and the resident's nurses' notes, dated 01/01/11 through 01/18/11, to indicate the physician had been notified of the blood sugars above 200. During an interview on 01/19/11 at 11:25 a.m., the Director of Nursing (DoN) indicated the physician had not been notified of the blood sugars above 200.	R 036	R 214 1. Residents will be weighed every 3 months to monitor weight. Residents with a weight change of 7.5% in last 3 months and 10% in six months will be followed up with their attending physician and the Dietary Director. Orders will be obtained from the physician within 24 hours of recognizing a significant change in condition. 2. All residents' weights were reviewed and no other residents had significant weight change. 3. Dietary Director will now receive and review weight reports to determine significant weight loss. The attending physician will be notified within 24 hours of determining significant weight loss. The Resident Care Coordinator or designee will then reevaluate the nursing needs for the resident. 4. The Dietary Director will review weight quarterly and report findings to consulting dietician, Resident Care Coordinator and also to the Quality Assurance Committee. 5. Completion date – February 4, 2011.	
R 214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to revise the evaluation with a known change in a resident's condition related to a weight loss for 1 of 7 residents reviewed for changes in condition in a sample of 7. (resident #4) Findings include: Resident #4's record was reviewed on 1/19/11 at 10:35 a.m. Resident #4's diagnoses included, but were not limited to, hypertension, congestive heart failure, and degenerative joint disease. A Resident's Vitals Chart indicated the resident's previous weight was 152 pounds (no date documented), 10/11/10 was 148, and the current	R 214		

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R 214	Continued From page 4 weight for January 2011 was 132 pounds. It also indicated a recheck weight of 133 pounds. A Nurse's Notes, dated 1/11/11, indicated "Resident's that gain more than 5 lb (pounds) or loast (sic) more than 5 lbs...(Resident #4's name) current weight 133 and previous weight 152..." During an interview with the DoN, on 1/19/11 at 11:10 a.m., she indicated "This is what was faxed to the doctor regarding the quarterly weights in which there were significant changes." A Nurse's Notes, dated 1/13/11 at 7:30 p.m., indicated "...noted to have wt (weight) loss of 19# (pounds). (physician's name) notified orders recvd (received) to refer to dietician..." A Physicians Order, dated 1/13/11, indicated "wt (weight) loss (arrow pointing down) may refer to dietician for eval (evaluation) et (and) tx (treat)." A Nutrition Risk Assessment, dated 10/12/10, was the last assessment done by the Dietician. During an interview with the DoN, on 1/19/11 at 11:10 a.m., she indicated the Dietician comes in monthly and is due to be coming back soon. She indicated the nurse should have called the Dietician about the weight loss, "I will call her right now." She also indicated, "we can start interventions before the Dietician sees them."	R 214		
R 217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident	R 217		

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R 217	Continued From page 5 shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to update residents' service plans, related to a toe wound and falls, for 2 of 7 residents reviewed for service plans in a sample of 7. (residents #4 and #23) Findings include: 1. Resident #23's record was reviewed on 01/19/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitis, end stage renal disease, and severe peripheral vascular disease.	R 217	R 217 Service plans in future will reflect wounds and falls. 1. New Service Plan form was implemented 2-1-11. Service Plans will reflect wounds and falls. Residents #4 & # 23 have revised service plans completed 2-7-11. 2. Wounds and falls will be added to all service plans. Falls were noted but will now be noted with each date of fall. All service plans will also include dates and interventions effective 2-4-11. Any resident with a fall or wound was affected by not having full information on the service plan. 3. New Service Plan form will be implemented that will reflect wounds and falls. The new form was implemented 2-1-11. Information regarding falls and wounds be added to new service plan by 2-18-11. 4. The Resident Care Coordinator will audit the falls report monthly to ensure falls and wounds are reflected on the service plans. Audit report will be presented at Q.A. Committee for six months. 5. Completion date – February 18, 2011.	

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R 217	Continued From page 6 A physician's order, dated 12/15/10 through 12/31/10, no time documented, indicated the resident had a left great toe wound, and Home Health would be completing the treatment as ordered by the physician and would provide physical therapy and occupational therapy. The resident's service plan, dated 10/26/10, indicated, "...home health as ordered.." There was a lack of documentation to indicate the resident had an open wound on her foot. During an interview on 01/19/11 at 11:25 a.m., the Director of Nursing (DoN) indicated the resident's service plan had not been updated. 2. Resident #4's record was reviewed on 1/19/11 at 10:35 a.m. Resident #4's diagnoses included, but were not limited to, hypertension, congestive heart failure, and degenerative joint disease. Nurse's Notes on the following dates and times indicated: 12/24/10 at 6:30 a.m. "Found sitting on buttocks next to w/c (wheelchair)..." 12/24/10 at 10:45 a.m. "Resident on floor between bed and w/c on buttocks..." 12/27/10 at 10:00 a.m. "Resident on floor in bedroom..." 12/28/10 at 7:30 a.m. "Noted lying supine (lying on back) next to recliner et (and) w/c..." 1/8/11 at 7:15 a.m. "...resident sitting on floor, stated slid down off recliner..." 1/14/11 at 8:00 a.m. "Res (resident) noted lying supine on bathroom floor next to toilet..." A Service Plan for Residential Care form, dated 12/20/10, indicated the resident is alert and forgetful, transfers self, toilets self with occasional bladder incontinence, needs assist with	R 217		

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R 217	Continued From page 7 decisions as needed for new situations/tasks, and has a hx (history) of falls. The Service Plan was not updated on the current falls. During an interview with the Don, on 1/19/11 at 1 p.m., she indicated she didn't know that needed to be put on the Service Plan. "I have new Service Plans I'm going to start using."	R 217		
R 241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. This RULE is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure physicians' orders were followed, related to high blood sugars not called, psychiatric consult not completed, laboratory tests not completed, and supplements not given as ordered for 4 of 7 residents reviewed for physicians' orders in a sample of 7. (residents #23, #25, #42, and #49) Findings include: 1. Resident #23's record was reviewed on 01/19/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitis, end stage renal disease, and severe peripheral vascular disease. A) The signed physician's recapitulation orders, dated 12/10 and 01/11, indicated an order for glucometer checks (blood sugar monitoring)	R 241	R 241 1. a.) Nursing staff was inserviced on monitoring blood sugar on 2-1-11. The resident #23 blood sugar monitoring order of over 200 or under 70 was discontinued. Order clarified with attending physician and the blood sugar monitoring order of notifying the physician when greater than 350 was correct. b.) Arrangements were made to obtain psychiatric evaluation for resident #23. c.) Resident #42 is now receiving health shakes. Dietary supplements were added to resident's diet card. d.) Resident #25 order for pro-time (PT) and international normalized ratio (INR) lab tests were discontinued.	

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R 241	Continued From page 8 twice a day at 6 a.m. and 4 p.m. and to notify the physician if the blood sugar was over 200 or less than 70. The physician's order indicated the resident was on a sliding scale (insulin given per blood sugar result) for insulin. The coverage for the insulin indicated to give eight units of Novolin N (insulin) for a blood sugar between 301-350 and if the blood sugar was greater than 350, the facility was to notify the physician. The Medication Administration Record (MAR), dated 12/10, indicated to notify the physician if the blood sugar was above 200 or less than 70. The MAR, dated 12/10, indicated the following 4 p.m. blood sugar results: 12/19/10-229 12/21/10-233 12/24/10-345 12/28/10-301 12/30/10-265 12/31/10-338 There was a lack of documentation on the MAR, dated 12/10 and in the resident's nurses' notes, dated 12/01/10 through 01/01/11, to indicate the physician had been notified of the blood sugars above 200. The MAR, dated 01/11, indicated to notify the physician if the blood sugar was above 200 or less than 70. The MAR, dated 01/11, indicated the resident's blood sugar at 6 a.m. on 01/02/11 was 313. The MAR, dated 01/11, indicated the following 4 p.m. blood sugar results: 01/07/11-268 01/11/11-301	R 241	2. a.) Audit was done of all residents on blood sugar monitoring and no other resident was affected. b.) Review all other resident charts and no other pending psychiatric evaluation order existed. No other resident was affected. c.) All dietary supplement orders were audited and no other resident was affected. d.) House wide audit done of standing lab orders and no other resident was affected. 3. a.) Review of recaps has been revised to include orders and medications. Beginning March 2011 all insulin orders will be on the medication side of the M.A.R. This will provide additional review by the pharmacy and the nursing staff to check the insulin orders. b.) Resident's receiving psychological evaluations will followed up within 24 hours. A physician Visit Log has been implemented to better communicate physician visits and order changes. Licensed nursing staff was inserviced on the Physician Visit Log on 12-30-10. Resident Care Coordinator or designee will also review physician orders to follow up with psychological evaluations	

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R 241	Continued From page 9 01/13/11-228 01/14/11-350 01/15/11-312 01/16/11-286 01/17/11-226 01/18/11-241 There was a lack of documentation on the MAR, dated 01/11, and the resident's nurses' notes, dated 01/01/11 through 01/18/11, to indicate the physician had been notified of the blood sugars above 200. During an interview on 01/19/11 at 11:25 a.m., the Director of Nursing (DoN) indicated the physician had not been notified of the blood sugars above 200. B) Resident #23's nurses' note, dated 11/24/10 at 2 p.m. indicated, "received a call from (Physician's name)...requesting for resident to have a psych (psychiatric) eval...." A nurses' note, dated 11/24/10 at 2:05 p.m., indicated, "spoke c/ (with) DoN aware of psych eval. stated she would notify psych Dr." The resident's record lacked documentation to indicate the resident had a psychiatric evaluation completed. During an interview on 01/19/11 at 11:25 a.m., the DoN indicated she was unaware of the request for a psychiatric evaluation. She indicated the evaluation had not been completed. 2. During an observation of the noon meal on 01/18/11 at 12:15 p.m., resident #42 was sitting in the dining room and had been served her lunch. The resident had not received a sugar free health	R 241	orders 5 days a week. c.) Dietary Director or designee will receive and review as the orders are received. Dietary Director or designee will add the dietary supplements to the resident's diet cards. d.) Lab orders will now be recorded on a Lab Log and reviewed 3 times a week on an ongoing basis by the medical records or designee. 4. a.) Resident Care Coordinator or designee will reviewed insulin dependent resident recaps on monthly basis. b.) All physician orders will be reviewed by the Resident Care Coordinator daily Monday thru Friday c.) Dietary Director or designee will review diet orders and supplements monthly on and ongoing basis. d.) Medical Records or designee will lab orders 3 times a week on an ongoing basis to ensure completion. 5. Completion date – February 18, 2011.	

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R 241	Continued From page 10 shake. During an interview on 01/18/11 at 12:40 p.m., the resident indicated she had not been receiving the health shakes. Resident #42's record was reviewed on 01/18/11 at 12:25 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. A nursing assessment form, dated 09/30/10 indicated the resident was oriented to person, place and time. The resident's admission orders, dated 03/31/09, indicated an order for, four ounces of sugar free health shake, twice daily at lunch and supper. The resident's signed physician's recapitulation orders, dated 12/10, indicated an order for a sugar free health shake at lunch and supper. A nutritional risk assessment form, dated 05/12/10 indicated, "resident receives...add'l (additional) nutrition per sf (sugar free) health shakes bid (twice a day)..." During an interview on 01/18/11 at 1:45 p.m., the Dietary Manager #1 indicated if the resident was suppose to get a health shake, they would serve it from the Dietary Department. She indicated the health shake was not on the resident's dietary card, so the resident had not been receiving it. 3. Resident #25's record was reviewed on 01/19/11 at 11:45 a.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus.	R 241		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 241	Continued From page 11 The resident's admission orders, dated 11/12/10, indicated an order for a pro-time (PT) and international normalized ratio (INR) (blood test for blood clotting) monthly. The resident's record indicated a PT/INR was completed on 11/26/10. There was a lack of documentation to indicate the resident had a PT/INR completed in December. During an interview on 01/19/11 at 12:10 p.m., LPN #3 indicated there was no PT/INR in the resident's record. LPN #3, then notified the laboratory company per telephone was informed there had not been a PT/INR completed for the resident in December. During an interview on 01/19/11 at 12:25 p.m., LPN #3 indicated the lab did not have the PT/INR scheduled. 4. Resident #49's record was reviewed on 01/19/11 at 12:35 p.m. The resident's diagnoses included, but was not limited to, hypothyroidism and chronic obstructive pulmonary disease. The resident was discharged from the facility on 10/23/10. A physician's order, dated 06/09/10, indicated an order for a CBC (complete blood count) and BMP (basic metabolic profile) (electrolytes) to be completed monthly. A signed physician's recapitulation order, dated 09/10, indicated an order for a CBC and BMP every month. The resident's record indicated the last BMP (Chem 8) and CBC was completed on 07/06/10 and the resident's potassium was 3.4 (normal	R 241		

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	002392	A. BUILDING _____ B. WING _____	01/19/2011

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R 241	Continued From page 12 3.5-5.3) and hemoglobin was 7.7 (normal 12-16). There was a lack of documentation to indicate another BMP and CBC was completed after 07/06/10. During an interview on 01/19/11 at 2:15 p.m., the DoN indicated she notified the laboratory company and the BMP and CBC had not been completed monthly as ordered.	R 241		
R 298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. This RULE is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure supplements stored in a medication refrigerator (A/B medication room) were not expired, failed ensure medications were not expired and labeled with resident names (A/B and C/D medication room), failed to ensure medication storage practices were followed related to food stored in a medication refrigerator and the refrigerator was	R 298	R 298 1. Refrigerators in both medication rooms have been cleaned and all outdated items and food have been removed. 2. Other refrigerators for use by the staff have been checked and no other issues were found. The refrigerators were cleaned and items labeled and dated. No outdated items were found. 3. Weekly cleaning schedules have been developed and implemented. The night nurse will be responsible. 4. The Resident Care Coordinator or designee will check the refrigerators and cleaning schedules weekly to ensure the refrigerators are clean and no outdate items or food are present. 5. Completion date – February 11, 2011.	

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R 298	Continued From page 13 dirty in the A/B medication room, which had the potential to affect 3 residents in a sample of 7 (residents #10, #23 and #42) and 5 residents in a supplemental sample of 5 (residents #1, #14, #21, #32, and #12), who had medication stored in the refrigerator and the other 38 of 47 residents who reside in the facility for 2 of 2 medications rooms. Findings include: During an observation of the C/D medication room on 01/19/11 at 1:45 p.m. with LPN #3, there was an unlabeled bottle of aspirin 81 milligrams with an expiration date of 07/10. During an interview at the time of the observation, LPN #3 indicated the night shift nurse is suppose to check the medication rooms. During an observation of the A/B medication room on 01/19/11 at 1:50 p.m. with LPN #3, there was one apple, eight sandwiches, bags of chips and sealed fruit cups stored in the medication refrigerator. There was one bottle of Boost (supplement) with an expiration date of 12/01/10, five bottles of Ensure (supplement) with an expiration date of 01/01/11, and sticky brown stains on the shelf of the refrigerator. There were five insulin pens without labels or resident names stored in the refrigerator, which were identified by LPN #3 as resident's #10 and #42's insulin pens. The A/B medication refrigerator also stored two vials of tuberculin and three vials of flu vaccine and a plastic container of emergency medications, which was used for the residents of the facility, bisacodyl suppositories (laxative) and insulin for resident #21, insulin vials for residents #1, #14, #23, #32, #42, and box of aerolizer	R 298		

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R 298	Continued From page 14 (nebulizer treatment) for resident #12. During an interview at the time of the observation, LPN #3 indicated the DoN (Director of Nursing) told dietary they could store the food in the refrigerator. During an interview on 01/19/11 at 4:40 p.m., the DoN indicated she did not mean for the dietary department to store the food in the medication refrigerator. She indicated the midnight nurse should be checking the medication room every night. A facility policy, dated 11/01/06, identified as current from the DoN, titled, "Medication Storage In The Facility", indicated, "...i. Refrigerated medications are kept in closed and labeled containers...separated from fruit juices, applesauce,and other foods...Other foods...are not stored in this refrigerator. j. outdated...medications...are immediately removed from stock...k. Medication storage areas are kept clean..."	R 298		
R 349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. This RULE is not met as evidenced by: Based on record review and interview, the facility	R 349	R 349 1. a.) Resident #23 dietary assessment was completed. b.) Resident #42 insulin order was clarified and insulin type was NOVOLOG and added to M.A.R. c.) Resident #25 did receive both the CMP and TSH laboratory tests in November. The physician has since d/c the lab order. d.) The T.A.R. was in error and the physician's order was for 9:00 p.m. e.) Correct weight was obtained for the resident and documented.	

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R 349	Continued From page 15 failed to ensure residents' records were complete and accurate related to dietary assessments and physician's orders for 4 of 7 resident's records reviewed in a sample of 7. (residents #10, #23, #25, and #42) Findings include: 1. Resident #23's record was reviewed on 01/19/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitis, end stage renal disease, and severe peripheral vascular disease. The record indicated the resident was readmitted into the facility on 12/15/10 from the hospital. The dietary assessment located in the resident's record was left blank. There were no dietary notes in the resident's record. During an interview on 01/19/11 at 4:20 a.m., Dietary Manager #2 indicated she had just started charting in the residents' charts and the Register Dietician should have documented on the resident. 2. Resident #42's record was reviewed on 01/18/11 at 12:25 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. The resident's admission orders, dated 03/31/09, indicated an order for NOVOLOG (insulin) per sliding scale (amount of insulin given per blood sugar result). The physician's recapitulation orders, dated 09/10, 12/10, and 01/11, indicated, "...inject--sub q (subcutaneously) per sliding scale for bid (twice	R 349	2. a.) Dietary Director reviewed resident charts and no other dietary assessment was missed. b.) Resident Care Coordinator audited all insulin orders on 1-20-11 and all insulin orders specified type of insulin. c.) House wide audit done of standing lab orders and no other resident was affected. d.) A review was done by the Resident Care Coordinator of all insulin orders on the T.A.R. and no other order had a change. e.) Weights reviewed and no other residents were affected. 3. a.) The dietary consultant was completing the dietary assessment and this has been changed to the Dietary Director. The Dietary Director is now completing the dietary assessments. b.) Insulin orders will reflect the type of insulin. Beginning March 2011 all insulin orders will be on the medication side of the M.A.R. This will provide additional review by the pharmacy and the nursing staff to check the insulin orders.	

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R 349	Continued From page 16 a day) glucometer (blood sugar check)..." There was a lack of documentation to indicate what the physician wanted injected. The resident's Medication Administration Record, dated 01/11, indicated, "...inject–sub q..." During an interview on 01/18/11 at 12:45 p.m., the DoN indicated the resident was getting regular Novolin insulin. At 12:55 p.m., the DoN indicated there is no documentation on the physician's orders or Medication Administration Record for what type of insulin to give. 3. Resident #25's record was reviewed on 01/19/11 at 11:45 a.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus. An order, dated 11/17/10, indicated a CMP (Comprehensive Metabolic Panel) (Electrolytes) and a TSH (thyroid test) laboratory test was to be completed every six months. The resident's physician's recapitulation orders, dated 12/10 indicated a TSH was to be completed every six months. The orders lacked documentation the CMP was to be completed every six months. During an interview on 01/12/11 at 12:10 p.m., LPN #3 indicated the CMP was omitted on the physician's recapitulation orders. 4. Resident #10's record was reviewed on 1/18/11 at 12:30 p.m. Resident #10's diagnoses included, but were not limited to, diabetes mellitus type 2, Alzheimer's disease, and hypertension. Resident #10 was admitted on 11/30/10. A.) Admission orders, dated 11/30/10, indicated	R 349	c.) Lab orders will now be recorded on a Lab Log and reviewed 3 times a week on an ongoing basis by medical records or designee. d.) Changes to T.A.R. will be clarified with the attending physician. Licensed nursing staff employees were inserviced on 2-1-11. Record changes will be initialed and dated. e.) Dietary Director will not use weight on preadmission assessment. Admission weight by nursing staff will be used 4. a.) Dietary Director will review the daily census to be aware of admissions and the need for a dietary assessment. Also, admission audit conducted by medical records will also include dietary assessment. b.) Lab orders will now be reviewed 3 times a week on an ongoing basis by medical records or designee. c.) Resident Care Coordinator or designee will reviewed insulin dependent resident recaps on monthly basis. d.) Insulin orders will be changed to the medication side of the MARs starting in March. This will provide addition pharmacy review to recheck the insulin	

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R 349	Continued From page 17 "Lantus (insulin) inject 10 units sub-q (subcutaneous) @ (at) 9 a.m." A TAR (Treatment Administration Record), dated 12/1/10 through 12/31/10, indicated "Lantus inject 10 units sub-q @ 9 a.m. order rewritten" No insulin had been initialed as given. An order for the Lantus written below it indicated, "Lantus inject 10 units sub q @ 9 p.m." The record lacked documentation of an order to change the time the insulin was to be given. During in interview with the DoN, on 1/18/11 at 1 p.m., she indicated "The nurse should have wrote 9 p.m. on the admission orders. The family said she got it at night." B.) An Assisted Living Pre-Admission Evaluation/Interview, dated 11/30/10, indicated "stated weight: 149..." A Vital Sheet, dated 11/30/10, indicated the resident's weight was 149 pounds but had a line through it marked with "ME" (mistaken entry) and a weight of 160 pounds was written. A Nutrition Risk Assessment, dated 12/21/10, indicated the resident's weight was 149 pounds and IBW (ideal body weight) was 114-151 pounds. On the back of the assessment, the Dietician indicated, "wt (weight) within IBW..." A Nutritional Assessment/Prescreening, dated 12/22/10, indicated "...weight 149...ideal weight 114-151..." During an interview with the DoN, on 1/18/11 at 1 p.m., she indicated they should not have used the pre-admission weight, that is a stated weight.	R 349	orders. Licensed staff will be inserviced on the change with the MARs 2-25-11. e.) Admission audit will be done to compare nursing assessment weight to dietary assessment weight to dietary assessment weight to check consistency. Medical records or designee will conduct the audit. 5. Completion date – February 7, 2011.	

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R 349	Continued From page 18 They should have used the actual weight of 160 pounds. An undated facility policy, titled, "Medical Records Documentation Policy For Assisted Living", received as current from the DoN on 01/19/11 at 12:15 p.m., indicated, "...The facility shall maintain an accurate and complete written medical record for each resident..."	R 349		
R 356	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident's emergency file contained pictures of the residents, for 3 of 7 residents reviewed for emergency files in a sample of 7. (residents #10, #23, and #25) Findings include:	R 356	R 356 1. The emergency information file was audited to ensure all current residents had an emergency information file that was accurate. All records are now complete as of January 19, 2011. 2. Photos were taken of residents whose files lacking photos. Photos were placed in emergency information file. Three residents were identified as being affected and have been corrected. 3. An admission audit will be completed within 72 hours of admission to ensure the admission process was adequately completed. The audit will be done weekly by medical records or designee. 4. The Resident Care Coordinator or designee will review the admission audit on a weekly basis to ensure completion. 5. Completion date – February 7, 2011.	

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R 356	Continued From page 19 1. Resident #23's record was reviewed on 01/19/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitis, end stage renal disease, and severe peripheral vascular disease. The record indicated the resident was readmitted into the facility on 12/15/10 from the hospital. The resident's emergency file did not contain a picture of the resident. 2. Resident #25's record was reviewed on 01/19/11 at 11:45 a.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus. The resident was admitted into the facility on 11/12/10. The resident's emergency file did not contain a picture of the resident. 3. Resident #10's record was reviewed on 1/18/11 at 12:30 p.m. Resident #10's diagnoses included, but were not limited to, diabetes mellitus type 2, Alzheimer's disease, and hypertension. Resident #10 was admitted on 11/30/10. The resident's emergency file did not contain a picture of the resident. During an interview on 01/18/11 at 1:25 p.m., the Director of Nursing indicated the pictures should be taken upon admission. She indicated she was aware they were not in the emergency file.	R 356		